DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/27/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185309	A. BUILDING _____ B. WING _____	09/02/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VIEW HEALTH & REHAB CENTER, INC	718 GOODWIN LANE LEITCHFIELD, KY 42754

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F 000	INITIAL COMMENTS AMENDED 2567 A standard and abbreviated (KY #15163 and KY #15164) survey was conducted 08/18/10 through 08/20/10 to determine the facility's compliance with Federal requirements. KY # 15164 was determined to be unsubstantiated. After supervisory review, KY # 15163 was re-opened on 08/30/10, and determined to be substantiated. Immediate Jeopardy was identified in the areas on 42 CFR 483.13 Resident Behaviors and Facility Practices, F223 S/S 'J', 42 CFR 483.15 Quality of Life, F250 S/S 'J', 42 CFR 483.20 Resident Assessment, F282 S/S 'J', and 42 CFR 483.75 Administration, F490 S/S 'J'. Substandard Quality of Care (SQC) was identified at 42 CFR 483.13 Resident Behaviors and Facility Practices, and 42 CFR 483.15 Quality of Life. An extended survey was conducted 08/30/10 through 09/02/10. The Immediate Jeopardy was identified on 08/30/10 and determined to exist on 07/11/10. The facility was notified of the Immediate Jeopardy on 08/30/10. An acceptable Allegation of Compliance (AoC) was received on 09/02/10, with the Immediate Jeopardy determined to be removed on 09/02/10, as alleged.	F 000		
F 223 SS=J	483.13(b), 483.13(b)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.	F 223	Submission of this Plan of Correction does not constitute admission or agreement by the provider of the truth or the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is submitted solely because it is required by the provision of federal and state law.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Beverly Shuelo | LNHA | 10/06/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 223	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record reviews, it was determined the facility failed to ensure each resident had the right to be free from mental, physical and sexual abuse. The facility failed to assess and implement effective interventions to prevent sexual abuse for four residents (#7, #14, #18 and #ZZ), in the selected sample of five. On 06/09/10, the facility identified Resident #16 as having behaviors of a sexual nature and became aware of Resident #16's history of sexual behaviors in other facilities on 06/15/10. While the facility implemented care plan interventions to address Resident #16's sexually aggressive behaviors, the facility failed to ensure those interventions were effective in managing the resident's behaviors and failed to identify and implement interventions to prevent potential abuse of other residents. Resident #16 began having sexually aggressive behaviors which impacted other residents of the facility on 07/10/10, and continued on 07/12/10, 07/15/10, 07/19/10 and 07/22/10. Furthermore, the facility while aware of these incidents, failed to ensure interventions implemented were effective in managing Resident #16's repetitive sexual behaviors and failed to provide appropriate supervision to prevent Resident #16 from abusing residents of the facility. Resident #16 touched Resident #7's pubic area while he/she was sitting on a sofa in the common area of the facility. Resident #16 had his/her hand in Resident #14's pants touching Resident #14's pubic area and Resident #14 was yelling for help. Resident #18 was in bed, during the night, when Resident #16 entered Resident #18's room and demanded sex from Resident #18. Resident #ZZ reported to	F 223	F223 483.13(b), 483.13(b)(i) **Free from Abuse / Involuntary Seclusion** It is the practice of Spring View Health & Rehab to honor residents right to be free from verbal, sexual, physical, and mental abuse, corporal punishment and involuntary seclusion. The facility does not use verbal, mental, sexual or physical abuse or involuntary seclusion. **Corrective Measures for Resident Identified in the deficiency:** **Resident #16** was placed on 1:1 monitoring on 7/22/10. He remained on 1:1 monitoring until the Resident #16 was discharged on 7/23/10 to a geriatric psych facility. **Resident #7** was assessed by nursing staff following the incident. No signs and symptoms of pain or distress were noted as evidenced by the nurses note of 7/22/10. The Social Service Director visited on 7/22/10 at 1000 and recorded that, " due to resident scoring very poorly on cognitive scale and diagnosis of late Alzheimer's, interview was ineffective." Resident #7 received follow up visits from Social Services and from the facility Administrator, who has previously been a Social Service Director, on at least eight separate occasions from 7/22/10 until 7/23/10, with notes describing each visit. Her physician visited on 8/31/10 and reported that she observed no ill effects from the encounter.	10/01/2010

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F 223	Continued From page 2 staff that Resident #16 had stood in his/her doorway and demanded sex. It was identified that the facility's failure to intervene to prevent abuse had placed residents at risk for serious injury, harm, impairment, or death to a resident receiving care in this facility. The findings include: A review of the facility Abuse/Neglect policy, dated 01/01/07 and revised 08/20/08, revealed sexual abuse defined as "an act of a sexual nature committed for the sexual gratification of the abuser and in the presence of a disabled adult or elderly person without the disabled adult's or elderly person's informed consent." Sexual abuse can include, but is not limited to fondling. Under the Identification section, the policy stated as part of the assessment process, residents will be reviewed to determine if the resident displays inappropriate behavior that could result in a catastrophic behavior incident. Interventions will be care planned as appropriate. Review of Resident #16's closed record revealed the facility admitted Resident #16 on 06/07/10 with diagnoses to include Dementia, Unspecified Mood Disorder and Alzheimer's Disease. Review of the physician orders upon admission revealed the facility was to follow up with psychiatric services for Resident #16. Review of the nurse's notes revealed Resident #16 began exhibiting verbally aggressive sexual behaviors towards staff on 06/09/10 at 2:00 PM, when Resident #16 stated to a Certified Nurse Aide (CNA) while she was providing assistance with toileting, "You like to shake it don't you" and "Let me see your boobs, come on let me see them". These	F 223	**F223 (continued)** **Resident #14** was assessed following incident, had fever of 99.2, but was currently receiving treatment for UTI. Social Service Director visited with resident on 7/22/10 following incident and visited twice again on 7/23/10 to follow up and observe for signs or symptoms of distress. Her visits and observations were recorded in the Social Service progress notes on 7/22/10 in an untimed entry, in subsequent entries on 7/22/10 at 1545 and 1930, on 7/23/10 at 0830 and 1430. Following the initial entry when she notes that the resident was "upset," each of the subsequent entries states that there were "no visual signs of distress." Interview with the Social Service Director indicates that the "visual signs" that she was looking for were things such as crying, tearfulness, fidgeting, facial expressions, changes in voice from normal. Additionally, the resident voiced that she was, "ok." On 7/23/10 resident was transferred to the hospital for an unrelated condition and her returned is not anticipated. **Resident#18** was admitted for short term rehab on 7/9/10 and was discharged on 7/14/10. After receiving the report of the incident, the Social Service Director visited the resident. She stated that the resident exhibited no signs of distress during the visit. During her stay, other than the nurses note on 7/11/10 when she reported the incident, she exhibited no indicators of mood or behavior symptoms.	

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F 223	Continued From page 3 behaviors continued on 06/15/10 at 12:00 PM, per the nurses' notes, which revealed Resident #16 remarked to another CNA during care, "Put it up (his penis)" and asked if the CNA was."Scared of it". Additionally, Resident #16 asked the CNA if she had "Ever been touched". The facility requested additional information about Resident #16's behavior history due to the behaviors exhibited on 06/09/10 and 06/15/10. On 06/15/10, the facility received information from a previous facility's History and Physical and signed as received by the Administrator, which revealed Resident #16 had a history of sexual behaviors at previous facilities. The facility developed a "Behavioral symptoms" care plan dated 06/15/10 which revealed the following interventions: 1. Explain that such behavior will not be tolerated; 2. Provide opportunities to vent aggressive feelings; 3. Always have 2 CNAs present when care provided; and, 4. Notify Social Services (SS) and Physician of any change in frequency of behaviors exhibited. There was no documented evidence the facility identified that Resident #16's sexual behaviors could potentially impact other residents of the facility and there was no documented evidence the facility implemented interventions requiring supervision to ensure other residents of the facility would not be impacted by these behaviors. Furthermore, there was no documented evidence the facility followed up with psychiatric services for Resident #16. On 06/20/10, the facility assessed, through the Resident Assessment Protocol (RAP), Resident #16 as having moderately impaired cognitive skills for daily decision making and socially inappropriate behaviors on the RAP. No	F 223	**F223 (continued)** Resident ZZ reported the incident to the Social Service Director during a quality assurance interview on 7/27/10. The Social Service Director followed up with her on 7/28/10, 7/29/10 and again on 8/5/10. Each of these interactions are recorded in the Social Service Progress Notes. The resident voiced no concerns with the situation and exhibited no signs of distress. She was also interviewed by the Administrator on 7/28/10. She relayed a similar account of events and stated, "I am a retired Social Worker. I know how to deal with people like that." A subsequent interview was conducted on 8/31/10, to make sure that there were no late effects from the event and the resident stated that she, "was fine and had not thought anything else about it." This resident is alert and oriented to person, place, and time. She is independent in her decision making and is her own clinical decision maker. **How other residents were identified who may have been impacted by the incident:** As part of the Quality Assurance process, the facility attempted to interview 100% of all female residents on 7/27/10 and asked, "Has anyone ever touched you or cared for you in a manner that you felt was inappropriate or made you uncomfortable?" and "Do you feel safe here at this facility?" One of the residents (Resident #ZZ) stated that a male resident who is no longer here had said something to her, but she had no	

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F 223	Continued From page 4 additional interventions were added to the resident's care plan dated 06/15/10. A nurse's note, dated 07/10/10 at 9:30 PM revealed Resident #16 was wandering in other residents' rooms and made the statement, "I want some pussy, go ask her to give me some pussy" and than called the staff "Sluts" when facility staff redirected. The note detailed the facility intervened by redirecting the resident. There was no other evidence of action the facility took to address this resident's behavior in order to prevent potential abuse of other residents. Nurse's notes, dated 07/12/10 at 9:30 AM, revealed, "Resident noted in 212 A, female bed, masturbating and ejaculated on bed; 212 A resident not in room". On 07/15/10 at 10:40 AM, a nurse's note entry revealed the resident had "Pants down fondling self". Interview on 08/20/10 at 8:30 AM revealed this behavior occurred in view of Resident #16's roommate. The nurse's note additionally revealed Resident #16 stated all the female staff were "Whores". Review of the "Behavior symptoms" care plan revealed the facility added the following interventions on 07/15/10: an alarm to Resident #16 top of door; to be monitored every 15 minutes; and pharmacist review meds. A phone interview on 08/20/10 at 4:55 PM with Resident #18 revealed Resident #16 had entered his/her room during the night and said, "Give me some" two times. Resident #18 yelled for the staff and nobody came but Resident #16 left the room when he/she yelled for staff. Resident #18 reported what had happened to the day shift nurse the next morning. Additionally, Resident #18 stated he/she had heard from "a lot of	F 223	**F223 (continued)** physical contact with him. Of the 43 residents that were interviewed, 27 were coded on the MDS as having severely impaired cognitive decision making, however, all but two provided sensible answers to the direct questions. A Resident's Council meeting was held on 7/27/10 to review what constituted abuse and how to report it if they were abused or suspected someone else was being abused. This review of recognizing and reporting abuse included sexual abuse. The Resident Council meeting was conducted by the Social Service Director. **Measures Implemented or Systems Altered to Prevent Re-occurrence:** A policy regarding Inappropriate Sexual Behavior Management was developed on 8/30/10. The policy contains information defining inappropriate behaviors and sexual abuse, and requirements for staff response. Staff were trained regarding this policy beginning on 8/30/10 and continuing with oncoming employees before they began work. Training was conducted by Director of Nursing, Quality Management Nurse, MDS Coordinator, and Nursing Supervisors. This education will be continued until all current employees were trained. Six employees remain on leave of absence and will be trained before their return to work. The Director of Nursing will be responsible to provide training to	

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F 223	Continued From page 5 work-hands that Resident #16 had done it to others" and said "the lady next door to me said Resident #16 had done it to her". Resident #18 did not know the resident's name. Resident #18 said what happened "Didn't make me feel very good" and "I'd put him/her in a cage". A review of a MDS assessment, dated 7/15/10, revealed Resident #18 was independent and had no cognitive impairment. On 08/20/10 at 9:45 AM, interview with LPN #2 confirmed that Resident #16 had entered Resident #18's room one night demanding sex and scared him/her. An interview with the Social Service Director (SSD), on 08/20/10 at 11:45 AM, revealed she was called, on 07/11/10 (Sunday), at home due to Resident #18 reporting to the day shift nurse that Resident #16 had entered his/her room demanding he/she "Give him/her some". The SSD thought Resident #16 was asking for sex. No incident report was completed because there was "no contact, no injury and the nurse would have done an incident report". The SSD stated she did not document anything in the Social Service Notes and had not implemented any new interventions. The facility was unable to provide evidence of action taken to prevent Resident #16 from exhibiting aggressive verbal sexual behaviors towards other residents. Nurse's note, dated 07/19/10 at 8:30 AM, revealed Resident #16 was found in another resident's bed and when redirected by the staff, he/she became aggressive and slapped at them. There was no evidence the facility implemented any further intervention other than redirection. An interview with Housekeeping Staff #1, on 08/18/10 at approximately 11:45 AM, revealed she saw Resident #16, on 07/22/10 in Resident #14's room. She observed Resident #16	F 223	**F223 (continued)** any employees that are not prior to their return to duty. The facility administrator was trained regarding the Inappropriate Sexual Behavior Monitoring policy on 8/30/10. She completed the Post test for training on 8/31/10. The requirement to report any suspected abuse including sexual abuse was reinforced along with a review of the Abuse Policy. Although education was provided regarding the entire abuse policy an emphasis was placed on recognizing sexual abuse and inappropriate behaviors and the need to report any suspected abuse of any kind. This education was initiated on 8/30/10 and was continued with oncoming employees before they began work. Training was conducted by Director of Nursing, Quality Management Nurse, MDS Coordinator,and Nursing Supervisors. This training was continued until all current employees were educated. The Director of Nursing will be responsible to provide training to any employees that are currently on leave of absence, prior to their return to duty, utilizing the previously described process. A policy was developed on 8/30/10 describing the process to be followed when providing behavior monitoring including one to one monitoring and 15 minute monitoring. A record for documenting 15 minute monitoring was included with the	

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F 223	Continued From page 6 standing over Resident #14's bed with his/her hand in the front of Resident #14's pants using his/her hand to "rub" Resident #14's pubic area inside Resident #14's pants. Resident #14 was yelling "help, help' and saying "Get off me". Housekeeper #1 yelled for help, entered the room and yelled "No, no, get off [him/her]". Resident #16 then "jerked" his/her hand out of Resident #14's pants. Resident #14 was "visibly upset and crying". Housekeeper #1 stated she "...almost started crying too. Resident #14 couldn't do anything". Additionally, the Housekeeper stated staff who entered the room to help (couldn't remember who) made the statement "Oh, that's what [he/she] has been yelling about". Record review revealed the facility had assessed Resident #14, MDS Assessment dated 07/14/10, as having modified independence cognitively with some difficulty in new situations only. Interviews with Resident #14, on 08/20/10 at 3:45 PM and on 08/30/10 at 1:20 PM revealed Resident #16 had pulled the cover back and "...put [his/her] hand inside my pants and touched me". Resident #14 told Resident #16 to "Stop" and staff came and escorted him/her out of the room. Resident #14 stated "I'm scared when I get out and somebody looks at me now". Resident #14 spoke softly but became loud and pressured when describing how he/she told Resident #16 to get out. An interview on 08/19/10 at approximately 5:50 PM, with Nurse Aide (NA) #1, revealed he was aware of Resident #16's behaviors of wandering. NA #1 stated Resident #16 had a favorite room (Resident #14's) located across the hall from him/her and required frequent redirection out of that room. An interview on 08/20/10 at 4:00 PM with family member #1 (former resident of the facility)	F 223	**F223 (continued)** policy. While monitoring is occurring the resident will remain on the 24 hour report, to further communicate the need to monitor. The charge nurse is responsible to assure that the monitoring is being completed and recorded during their shift. The individual monitoring sheets will be reviewed by the Unit Managers and / or the Director of Nursing at or just prior to each morning AQA meeting to validate completion. Education for this policy and process was started on 8/30/10 and was continued with oncoming workers in all departments at the start of their shift before reporting for duty. The training was provided by the Director of Nursing, MDS Coordinator, Quality Management Nurse, and Nursing Supervisors. The Director of Nursing will be responsible to provide training to any employees that are currently on leave of absence prior to their return to duty, utilizing the previously described process. A post test was given to verify understanding of the abuse policy, reporting requirements and recognizing inappropriate sexual behavior at the conclusion of the training. The Administrator successfully completed the post test with a score with 100% accuracy. Education of the Inappropriate Sexual Behavior Management Policy and the Behavior Monitoring Policy have been added to the orientation materials that are covered with the Abuse Policy at the time of hire.	

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F 223	Continued From page 7 revealed he/she had witnessed on 07/22/10, Resident #16 rubbing Resident #7's leg and then moved his/her hand and began rubbing Resident #7's pubic area. Resident #7 was half asleep on the couch and did not know what was happening. The family member stated "It made me feel bad". Review of a nurse's note, dated 07/22/10 at 3:20 PM, revealed Resident#16 was observed pulling the cover off a female resident and told staff he/she was "up to meanness". On 08/31/10 at 3:15 PM, interview with Resident #ZZ (identified by the facility during the investigation of 07/22/10 incident), who the facility assessed as cognitively independent, revealed Resident #16 had been to the doorway of his/her room on two occasions and requested sex. Resident #ZZ stated he/she remembered telling a nurse but could not recall who and told the Social Service Director on 07/27/10. On 08/20/10 at 9:45 AM, an interview conducted with LPN #2 revealed Resident #16 had entered other residents' rooms several times and Resident #16 would wait for one resident to leave a room, leaving the other resident alone. Resident #16 knew what he/she was doing and at no time did she see him/her confused as he/she focused on female residents. LPN #2 stated Resident #16 made her feel "uneasy". An interview conducted with LPN #1, on 08/20/10 at approximately 8:30 AM, revealed Resident #16 had behaviors of staring at everybody's bottoms and entering other residents' rooms. LPN #1 stated she thought Resident #16 had a purpose for entering some rooms in particular and thought he/she "preyed on female residents". She also	F 223	**F223 (continued)** **Monitoring Measures to Maintain On-going Compliance:** Review of the 24 hour Nursing reports will be conducted daily, by the Director of Nursing or Unit Managers in her absence, to identify the onset of or changes in, behaviors that are sexually inappropriate. On weekends and holidays the on call nurse will verbally review the 24 hour reports by phone to identify a new onset of sexually inappropriate behaviors. If sexually inappropriate behaviors are identified, the on call nurse will come in to review interventions which are to be based on the assessment of contributing / causative factors and report findings to the Director of Nursing and / or Administrator. Such interventions include but are not limited to: treat the underlying condition, separate residents involved if unable to consent, relocate resident who exhibits behaviors to a private room if roommate is at risk, provide diversional activities, obtain psychiatric evaluation or treatment, medication plans, provide privacy if resident is sexually aroused, remind resident of boundaries of what is inappropriate, don't encourage inappropriate behaviors by joking with resident about them, provide positive feedback to resident for appropriate behaviors.	

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F 223	Continued From page 8 stated the last incident, on 07/22/10 with Resident #14 was a deliberate choice because Resident #14 was non-ambulatory and located directly across from Resident #16. Additionally, LPN #1 stated the facility had placed a door alarm on Resident #16's door because he/she had been in other residents' rooms touching him/herself. The facility had utilized 15 minute checks but "In 15 minutes Resident #16 could do what he/she did to Resident #14". LPN #1 stated, "I was scared of Resident #16 myself" and had told the administrative staff. An interview on 08/20/10 at 12:20 PM, with the Director of Nursing (DON), revealed nurses were responsible to ensure a resident's care plan was updated if an immediate intervention was needed. She thought Resident #16 had been on 15 minute checks but on 07/15/10 she had added "to be monitored every 15 minutes" with a date of 07/10/10. Additionally, on 07/15/10, "alarm to top of door" and Pharmacist reviewed meds" was added. The DON did not know if the 15 minute checks were placed on the Nurse Aide care plan. Interviews with LPN #2 on 08/20/10 at 8:30 AM, LPN #1 on 08/20/10 at 9:45 AM, the SSD on 08/20/10 at 11:45 AM, and CNA #3 on 08/20/10 at 3:10 PM, revealed they thought Resident #16 might have been on 15 minute checks off and on but no particular staff was assigned as responsible to ensure the checks were completed and no flow sheet was utilized to verify if checks were completed. A review of the Nurse Aide Data Sheet (not dated) revealed two assist with all care and door alarm for a safety device. The Nurse Aide Data Sheet did not indicate 15 minute checks. The Behavior Interventions sections was blank. The care plan titled "Behavioral symptoms	F 223	**F223 (continued)** A follow up post test to validate on-going understanding of education including, Abuse & Neglect, reporting of abuse, recognition of sexually inappropriate behaviors, reporting sexually inappropriate behaviors, and managing sexually inappropriate behaviors. The testing will be conducted every two weeks for eight weeks. If results indicate that someone doesn't understand, re-education will be provided on an individual basis. After eight weeks, if results of testing indicate understanding, re-testing will be conducted monthly for six months then quarterly. Monthly re-education will be conducted for three months then will be conducted quarterly by the Social Service Director, Director of Nursing, Quality Management Nurse or a guest speaker.	

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F 223	Continued From page 9 (#6145) revealed 15 minute checks, dated 07/10/10 that the DON had stated she actually placed on the care plan on 07/15/10. No other documentation for 15 minute checks could be verified. An interview with the Administrator conducted 08/19/10 at approximately 6:35 PM, revealed Resident #16's behaviors had been discussed in the morning meetings and staff were told to present reality and that his/her behaviors were unacceptable. Resident #16 had been admitted with orders to follow up with psychiatric service and a psychiatric evaluation was discussed sometime during Resident #16's first week after admission; however, no behaviors were documented for about a month so the psychiatric evaluation was not obtained. The Administrator further revealed the facility had initiated 15 minute checks of Resident #16 due to inappropriate behaviors but the facility had no method utilized to determine who was completing the checks. Furthermore, the facility had no policy and procedure for 15 minute checks. The Administrator confirmed that the facility did not initiate 1:1 supervision of Resident #16 until 07/22/10, after the resident was observed by staff with his/her hand in Resident #14's pants, rubbing the resident's pubic area. The facility then initiated transfer of Resident #16 to a geriatric psychiatric facility on 07/23/10. An acceptable Allegation of Compliance (AoC) was received 09/02/10. On 07/22/10 Resident #16 was placed on 1:1 monitoring immediately after the incident and remained on 1:1 monitoring until 07/23/10 when he/she was discharged to a geriatric psychiatric facility. Resident #14 was assessed following the incident. The SSD visited	F 223		

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F 223	Continued From page 10 with the resident on 07/22/10 following the incident and twice again on 07/23/10 to follow up and observe for signs and symptoms of distress as crying, tearfulness, fidgeting, facial expressions and changes in voice from normal. Resident #14 was discharged to a hospital on 07/23/10 with a diagnosis of Pneumonia and is no longer a resident at the facility. Resident #7 was assessed by nursing staff following the incident and showed no signs and symptoms of pain or distress. The SSD and Administrator (a former Social Worker) visited Resident #7 eight times from 07/22/10 to 07/28/10. The resident did not show any changes in behavior as crying, tearfulness or unpleasantness which would have been abnormal for this resident. The actions taken to verify the removal of Immediate Jeopardy included review of the policy developed regarding Inappropriate Sexual Behavior Management on 08/30/10. Verified training was completed for the Administrator, SSD and staff were trained by Quality Management Specialist Nurses regarding this policy beginning on 08/30/10 and continuing with on-coming employees before they began work. A review was conducted of the Abuse Policy with an emphasis placed on recognizing sexual abuse and inappropriate behaviors and the need to report any suspected abuse of any kind. A review of the policy developed on 08/30/10 described the process to be followed when providing behavior monitoring including 1:1 monitoring and every 15 minute monitoring. The completion of the post test taken by the Administrator and staff to verify understanding was reviewed. The Director of Nursing, MDS Coordinator, Unit Managers, SSD, Activity Director, Dietary Director, Rehab Director and Administrator were provided training	F 223		

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F 223	Continued From page 11 regarding updating the plan of care as conditions arise and monitoring the effectiveness of the approaches that were in place. The training was conducted by Quality Management Specialist Nurses on 08/31/10. A review of the new Inappropriate Sexual Behavior Management policy dated, 08/30/10, was conducted 08/31/10. Interviews with the Administrator and SSD confirmed they were in-serviced by the Quality Management Specialist Nurses on 08/30/10. Interviews were conducted with CNAs, LPNs and RNs to confirm they had received the in-service related to the new Inappropriate Sexual Behavior Management policy. The DON was responsible to maintain a list of employees not readily available for training and testing to ensure the training was completed prior to their return to duty. Additionally, education of the Abuse Policy was provided regarding the entire abuse policy and inappropriate behaviors and recognizing sexual abuse. This education was verified initiated on 08/30/10 and was continuing with on-coming employees before they began work. This training was conducted by the DON, Quality Management Nurse, MDS Coordinator and Nursing Services. The DON was to be responsible to provide the training to any remaining employees before their return to duty. Interviews on 09/01/10 and 09/02/10 conducted with CNAs, LPNs and RNs confirmed they had received the in-services and training related to the new Inappropriate Sexual Behavior Management policy. The staff were able to verbalize their knowledge of the new policy and review of the in-service sign in sheets verifying their attendance and their completion of the post tests. The Administrator and SSD were in-serviced and completed a post test with 100%	F 223		

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F 223	Continued From page 12 accuracy. Extended reviews and interviews of facility residents revealed no concern. The Immediate Jeopardy was verified removed on 09/02/10, as alleged in the AoC, with the scope/severity lowered to a "D", based on the facility's need to continue to evaluate the implementation of systematic changes.	F 223		
F 250 SS=J	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, it was determined the facility failed to ensure appropriate and timely social services was provided for two residents (#16 & #18), in the selected sample of 5. The Social Service Director (SSD) failed to promote the general well being of each resident through identification of their emotional and psychosocial needs and failed to ensure effective interventions were developed and implemented when residents exhibited behaviors which resulted in negative outcomes to the resident or other residents of the facility. On 06/09/10, the facility identified Resident #16 as having behaviors of a sexual nature and became aware of Resident #16's history of sexual behaviors in other facilities on 06/15/10. While the facility implemented care plan interventions to address Resident #16's sexually aggressive behaviors, the facility failed to ensure those	F 250	F250 483.15(g)(1)Provision of medically related Social Service It is the routine practice of this facility to provide medically related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. Corrective Measures for Resident Identified in the deficiency: Resident #16 was placed on 1:1 monitoring on 7/22/10. He remained on 1:1 monitoring until the Resident #16 was discharged on 7/23/10 to a geriatric psych facility. Resident#18 was admitted for short term rehab on 7/9/10 and was discharged on 7/14/10. After receiving the report of the incident, the Social Service Director visited the resident. She stated that the resident exhibited no signs of distress during the visit. During her stay, other than the nurses note on 7/11/10 when she reported the incident, she exhibited no indicators of mood or behavior symptoms.	10/01/2010

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F 250	Continued From page 13 interventions were effective in managing the resident's behaviors and protecting other residents within the facility. Resident #16 began having sexually aggressive behaviors which affected other residents of the facility on 07/10/10, and continued on 07/12/10, 07/15/10, 07/19/10, and 07/22/10. The failure to effectively address and manage Resident #16's sexually aggressive behaviors resulted in two residents (#7 and #14) being sexually abused by Resident #16. Additionally, the facility failed to ensure the emotional and psychosocial needs of Resident #18 were met after Resident #18 reported Resident #16 entered his/her room during the night and demanded sex. It was identified that the facility's failure to intervene, manage and supervise behavior's to prevent abuse had placed residents at risk for serious injury, harm, impairment, or death to a resident receiving care in this facility. The findings include: A review of the SSD Job Description, undated, included the SSD functions on behalf of the nursing home and its' residents by promoting the general well being of each resident through identification of their emotional and psychosocial needs and works with staff in developing a means to meet and sustain these needs. Additionally, assures timely progress notes on each resident in the facility. An interview with the Administrator, on 08/20/10 at 5:20 PM, revealed the SSD's duties included completing mood and behavior assessments and developing behavior care plan interventions, when behaviors were exhibited. 1. Review of Resident #16's closed record	F 250	F250 (continued) **How other residents were identified who may have been impacted by the incident:** As part of the Quality Assurance process, the facility attempted to interview 100% of all female residents on 7/27/10 to identify other residents who may have been impacted by the incident. Of the 43 residents that were interviewed, 27 were coded on the MDS as having severely impaired cognitive decision making, however all but two provided sensible answers to the direct questions. A Resident Council meeting was held on 7/27/10 to review what constituted abuse and how to report it if they were abused or suspected someone else was being abused. This review of recognizing and reporting abuse included sexual abuse. The Resident Council meeting was conducted by the Social Service Director. Clinical records were reviewed to identify other residents who exhibit behaviors that may suggest that they have the potential to exhibit inappropriate sexual behaviors toward residents in the future. This review was completed using daily tracking records which identify behavior MDS indicators including physical and verbal abuse. The records of these residents were reviewed and the care givers for these residents interviewed to identify if any behaviors were of a sexual nature. None were identified. This review was completed by	

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F 250	Continued From page 14 revealed the facility admitted Resident #16 on 06/07/10, with diagnoses to include Dementia, Unspecified Mood Disorder and Alzheimer's Disease. Review of the admission physician orders revealed the facility was to follow up with psychiatric services for Resident #16. On 06/09/10, Resident #16 began exhibiting sexual behaviors toward staff and continued these behaviors on 06/15/10. On 06/15/10, the Administrator received a History and Physical from another facility where Resident #16 resided in the past which revealed Resident #16 had a history of sexual behaviors at previous facilities. The facility developed a "Behavioral Symptoms" care plan dated 06/15/10, which revealed the following interventions: 1. Explain that such behavior will not be tolerated; 2. Provide opportunities to vent aggressive feelings; 3. Always have 2 CNAs present when care provided; and, 4. Notify Social Services (SS) and Physician of any change in frequency of behaviors exhibited. A review of the Minimum Data Set (MDS) Assessment dated 06/20/10, revealed the facility assessed Resident #16 as having moderate cognitive impairment with supervision required. The facility identified Resident #16 as having socially inappropriate behaviors on the Resident Assessment Protocol (RAP), dated 06/20/10 and referred to sexual remarks made to staff but no additional interventions were implemented at that time. Record review revealed Resident #16 began exhibiting sexual behaviors impacting other residents of the facility by entering other residents' rooms and making sexual remarks, masturbating and ejaculating on a another	F 250	**F250 (continued)** Quality Management Specialist Nurse, Director of Nursing and Unit Managers. The review was completed on 09/30/2010. **Measures Implemented or Systems Altered to Prevent Re-occurrence:** On 8/31/10 re-education was conducted with the Social Service Director by the Quality Management Nurse. The re-education included review of the Social Service Director's Job Description, Abuse and Neglect Policy including the types of abuse, identifying abuse and reporting requirements. An emphasis was placed on sexual abuse and sexually inappropriate behaviors as well as participation in the development of care plans and interventions to address sexually inappropriate behaviors and to promote the safety and wellbeing of other residents. The Social Service Director was able to list the types of abuse, provide examples of each abuse type, including sexual, physical, mental, verbal, corporal punishment, exploitation, or involuntary seclusion and describe the abuse reporting process. In the same training session, the Social Service Director was re-educated regarding utilizing the admission history and assessment process to aid in identifying potential risks for inappropriate sexual behaviors. If potential risks are identified the Social Service Director was trained to notify the Administrator and /or Director of Nursing or the On-Call designee if both are	

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F 250	Continued From page 15 resident's bed, fondling him/herself in front of another resident and slapping at staff when redirected which began on 07/10/10 and continued on 07/12/10, 07/15/10, 07/19/10 and 07/22/10. On 07/22/10, per interview housekeeping staff observed Resident #16 rubbing Resident #14's pubic area inside the resident's pants. Interview with family member #1 (a former resident of the facility) on 08/20/10 at 4:00 PM, revealed the family member observed Resident #16 rubbing Resident #7's leg and then moved his/her hand and began rubbing Resident #7's pubic area. There was no evidence that social services addressed Resident #16's repetitive sexual behaviors since the implementation of the care plan on 06/15/10. 2. A review of a MDS assessment, dated 07/15/10, revealed the facility had assessed Resident #18 as independent and with no cognitive impairment. Resident #18 was admitted to the facility on 07/09/10 for short term rehabilitation. Review of the nurse's notes, dated 07/11/10 at 9:00 AM, revealed Resident #18 reported to facility staff that Resident #16 was in his/her room during the night, demanded sex and left the room when Resident #18 yelled for the nurses. The nurse's note revealed Resident #18 was "upset" and requested that his/her room door be kept shut. An interview with Licensed Practical Nurse (LPN) #2, on 08/20/10 at 9:45 AM, revealed Resident #18 told her on the morning of 07/11/10, that Resident #16 came in his/her room the previous night and asked for sex. LPN #2 notified the on-call supervisor who was the SSD. During an interview with Resident #18, on 08/20/10 at 4:55 PM, Resident #18 stated that the incident "didn't make me feel very good". Additionally, Resident #18 stated staff had told	F 250	**F250 (continued)** not available. If immediate intervention is required she was trained to notify the charge nurse of the potential risk and assist in the development of the care plan and interventions to manage the potential risk. Additional training was provided to the Social Service Director on 9/1/10 by the Quality Management Specialist. The training included recording in objective terms, noting specific observations that are described clearly using words to paint a visual picture,observing for mood and behavior indicators to aide in assessing for changes in condition. Instruction was given to utilize quotations by the residents to help describe feelings objectively. The training also instructed to document situations and conditions that occur between routine quarterly documentation that may have impact on the residents psychosocial functioning. This would include such events as newly identified or worsening of behavioral symptoms, need for outside services, a change in medical condition that impacts overall condition, changes in family or close relationships, responses to stressful situations or unusual/traumatic events. She was trained that documentation was to be done as soon as possible following the event within the same workday so that details of observations are clear. Training also included the need for gathering complete and accurate social history and assessment to utilize the information to identify risk for behaviors or conditions that require social service or	

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F 250	Continued From page 16 him/her that Resident #16 did it to others and it was not good for them. Further review of the record revealed no evidence the facility addressed the incident through Social Services with Resident #18. An interview with the SSD, on 08/20/10 at 11:45 AM, revealed she had been working as the SSD since 07/01/10 with experience working in this position from 06/2009 through 03/2010. The SSD revealed she was called on 07/11/10 (Sunday), at home, due to Resident #18 reporting to the day shift nurse that Resident #16 had entered his/her room demanding he/she "give him/her some". The SSD thought Resident #16 was asking for sex. The SSD stated that no incident report was completed because there was "no contact, no injury and the nurse would have done an incident report". The SSD stated after reading the Resident #18's nurse's notes, dated 07/11/10 at 9:00 AM, the incident "looks like verbal sexual abuse". The SSD did not document anything in the Social Service Notes and stated she would "normally chart something like that" and did not know why she had not. She stated she was responsible to document when residents had behaviors and update the behavior care plans, but she had not implemented any new interventions for Resident #18 because he/she was not "upset" and she did not follow up with Resident #18. The SSD described her duties as "making sure residents were not abused, and care plan what they need". Additionally, she stated if the nurse contacted her, she was to take it to the Director of Nursing (DON) and Administrator. However, the SSD stated she did not personally take it to them, it was on the 24 hour report. Additionally, she remembered discussing the incident at the next day's	F 250	**F250 (continued)** interdisciplinary intervention. It was also explained that information gathered is to be utilized in developing the MDS, RAPS and Care Plan. The Social Service Director also participated in a three day Social Service Seminar presented by the Kentucky Association of Health Care Facilities. **Monitoring Measures to Maintain On-going Compliance:** A ten percent sample of charts were reviewed to verify that medically related social services were identified and provided as needed. The reviews were conducted by Quality Management Nurse (QMS) and Administrator. An additional ten percent will be reviewed monthly for three months by the QMS or Administrator. If concerns are identified, the frequency and or quantity of reviews will be increased and further education will be provided.	

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F 250	Continued From page 17 (07/12/10) meeting but did not recall what was determined and could only speculate Resident #16 was "Put on alert and was watched". An interview with the Administrator, on 08/20/10 at 5:20 PM, revealed the SSD did not complete his/her assigned duties as it related to addressing Resident #16's persistent sexual behaviors to the incidents and confirmed that the SSD had totally forgotten about addressing the needs of Resident #18 after the incident of 07/10/10. An acceptable Allegation of Compliance (AoC) was received 09/02/10. The actions taken to verify the removal of Immediate Jeopardy included a policy developed regarding Inappropriate Sexual Behavior Management on 08/30/10. On 08/31/10 the SSD was re-educated regarding utilizing the admission history and assessment process to aide in identifying potential risks for inappropriate sexual behaviors. If potential risks were identified the SSD was trained to notify the Administrator and/or DON or the on-call designee if both are not available. If immediate intervention was required she was trained to notify the charge nurse of the potential risk and assist in the development of the care plan and interventions to manage potential risk. Additional training was provided to the SSD on 09/01/10 by the Quality Management Specialist. The training included recording in objective terms, noting specific observations that were described clearly using words to paint a visual picture, observing for mood and behavior indicators to aide in assessing for changes in condition. The training also instructed to document situations and conditions that occurred between routine quarterly documentation that may have impacted on the residents' psychosocial functioning. Social	F 250		

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F 250	Continued From page 18 Services would be involved in the assessment of the residents' behaviors. Interview with the SSD, on 09/01/10, verified the re-education and she was able to verbalize understanding of the education regarding utilizing the admission history and assessment process to aide in identifying risks for behaviors. She verified she would notify the Administrator and/or DON or the on-call designee if both were not available. Training by the Quality Management Specialist was verified 09/02/10 as completed 09/01/10. The training included documentation, observation of mood indicators to aide in assessing changes in behaviors that could impact a resident's psychosocial functioning. The Immediate Jeopardy was verified removed on 09/02/10, as alleged in the AoC, with the scope/severity lowered to a "D", based on the facility's need to continue to evaluate the implementation of systematic changes.	F 250		
F 282 SS=J	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on interviews and record review, it was determined the facility failed to provide services were provided in accordance with the care plan for two (2) residents (#5 and #16) in the selected sample of nineteen (19). On 06/19/10 the facility identified Resident #16 as having behaviors of a	F 282	**F282** 483.20(k)(3)(ii) Services by Qualified Persons/per Care Plan It is the routine practice of Spring View Health and Rehab to provide or arrange for services to be provided by qualified persons in accordance with each resident's written plan of care. **Corrective Measures for Resident Identified in the deficiency:** Resident #16 was placed on 1:1 monitoring on 7/22/10. He remained on 1:1 monitoring until the Resident #16 was discharged on 7/23/10 to a geriatric psych facility.	10/01/2010

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	185309	A. BUILDING _____ B. WING _____	09/02/2010

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F 282	Continued From page 19 sexual nature and became aware of Resident #16's history of sexual behaviors in other facilities on 06/15/10. While the facility implemented care plan interventions to address Resident #16's sexual behaviors, the facility failed to ensure those interventions were effective in managing the resident's behaviors and failed to identify and implement interventions to prevent potential abuse of other residents. Resident #16 began having sexually aggressive behaviors which impacted other residents of the facility on 07/10/10, and continued on 07/12/10, 07/15/10, 07/19/10 and 07/22/10. Furthermore, the facility while aware of these incidents, failed to ensure interventions implemented were effective in managing Resident #16's repetitive sexual behaviors and failed to provide appropriate supervision to prevent Resident #16 from abusing residents in the facility. Resident #16 touched Resident #6's pubic area while h/she was sitting on a sofa in the common area of the facility. Resident #16 had his/her hand in Resident #14's pants touching Resident #14's pubic area and Resident #14 was yelling for help. Resident #18 was in bed, during the night, when Resident #16 entered Resident #18's room and demanded sex from Resident #18. Resident #ZZ reported to staff that Resident #16 had stood in his/her doorway and demanded sex. In addition, Resident #5 was transferred on 07/03/10 by one staff instead of two staff as per the resident's care plan, resulting in a fall. It was identified the facility's failure to develop and implement effective care plan interventions to manage resident's behaviors and prevent abuse placed residents at risk for serious injury, harm,	F 282	**F282(continued)** Resident #5: will be transferred utilizing two staff members in accordance with the resident's plan of care. CNA #3 was re-educated by the DON on 9/1/10 and verbalized understanding. CNAs working on Resident #5's unit on 07/03/10 will be re-trained by nurse unit managers and required to give return demonstration to validate following the Nurse's Aid Data Sheet as required. This training will start on 09/07/10 and will be completed by 09/10/10. **How Other Residents were Identified that may have been impacted by this practice:** Transfer requirements on the Nurse Aide Data Sheets were reviewed by the Nursing Unit Managers and Care Plan Coordinator. The review was completed on 9/7/10. The findings of the review revealed that 22 residents on 100 hall and 21 residents on 200 hall required more than one person to assist with transfers. The C.N.A.s who provide care for the residents identified as needing more than 1 person for transfers, were interviewed by the Unit Managers and C.N.A. Manager to verify that they understood the requirement to follow the nurse aide data sheet, without deviation. These interviews were completed on 9/9/10. All C.N.A.s interviewed correctly identified the required amount of assistance and validated that they understood that the Nurse Aide Data Sheet was to be followed, with no one being unaware of the required assistance. As part of the Quality Assurance process, the facility attempted to interview 100% of all female residents on 7/27/10 and asked. "Has anyone ever touched you or cared for you in a manner that you felt was inappropriate or made you uncomfortable?" and "Do you feel safe here at this facility?" Of the 43 residents that	

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F 282	Continued From page 20 impairment, or death to a resident receiving care in this facility. The findings include: 1. A review of the facility Abuse/Neglect policy, dated 01/01/07 and revised 08/20/08, revealed sexual abuse defined as "an act of a sexual nature committed for the sexual gratification of the abuser and in the presence of a disabled adult or elderly person without the disabled adult's or elderly person's informed consent." Sexual abuse can include, but is not limited to, fondling. Under the Identification section, the policy stated as part of the assessment process, residents will be reviewed to determine if the resident displays inappropriate behavior that could result in a catastrophic behavior incident. Interventions will be care planned as appropriate. A review of the facility policy and procedure titled "Comprehensive Care Plans", dated 04/16/08 and revised 03/25/09 and 09/17/09, included: a care plan will be developed based on assessed needs and the plan of care will be reviewed and revised when indicated, based on the resident's response. Review of a closed record revealed Resident #16 was admitted to the facility, on 06/07/10, with diagnoses to include Dementia, Unspecified Mood Disorder and Alzheimer's Disease. A nurse's note, dated 06/09/10 at 2:00 PM, revealed a Certified Nurse Aide (CNA) was assisting him/her with a urinal, when he/she stated, "You like to shake it don't you" and "Let me see your boobs, come on let me see them". No interventions were added to the care plan at this	F 282	**F282 (continued)** were interviewed, 27 were coded on the MDS as having severely impaired cognitive decision making, however all but two provided sensible answers to the direct questions. A Resident Council meeting was held on 7/27/10 to review what constituted abuse and how to report it if they were abused or suspected someone else was being abused. This review of recognizing and reporting abuse included sexual abuse. The Resident Council meeting was conducted by the Social Service Director. Clinical records were reviewed to identify other residents who exhibit behaviors that may suggest that they have the potential to exhibit inappropriate sexual behaviors toward residents in the future. This review was completed using daily tracking records which identify behavior MDS indicators including physical and verbal abuse. The records of these residents were reviewed and the care givers for these residents interviewed to identify if any behaviors were of a sexual nature. None were identified. This review was completed by Quality Management Specialist Nurse, Director of Nursing and Unit Managers. The review was completed on 09/30/2010 . **Measures Implemented or Systems Altered to Prevent Re-occurrence:** Re-education will be initiated on 9/7/10 by Director of Nursing & CNA Manager to re-train all CNAs on following the Nurse Aide Data Sheets for transfer requirements as established by the interdisciplinary care plan team and, emphasizing that no less assistance can be provided by staff than is specified on the nurse	

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F 282	Continued From page 21 time. On 06/15/10, the facility received a History and Physical document which detailed Resident #16's sexually aggressive behavior history at other facilities. The History and Physical revealed Resident #16 had a history of pacing, wandering in others' rooms and acting sexually inappropriate. Additionally, a review of a nurse's note entry, dated 06/15/10 at 12:00 PM, revealed Resident #16 remarked to a CNA, while she was providing care, "Put it up (his penis)" and asked if the CNA was "Scared of it". Resident #16 asked the CNA if she had "Ever been touched". The facility developed a "Behavioral symptoms" care plan dated 06/15/10 which revealed the following interventions: 1. Explain that such behavior will not be tolerated; 2. Provide opportunities to vent aggressive feelings; 3. Always have 2 CNAs present when care provided; and, 4. Notify Social Services (SS) and Physician of any change in frequency of behaviors exhibited. There was no documented evidence the facility identified that Resident #16's sexual behaviors could potentially impact other residents in the facility and there was no documented evidence the facility implemented interventions requiring supervision to ensure other residents in the facility would not be impacted by these behaviors. The facility assessed the resident as having moderately impaired cognitive skills for daily decision making and socially inappropriate behaviors on the Resident Assessment Protocol (RAP), dated 06/20/10. Further review revealed no evidence of changes made to the care plan addressing Resident #16's sexually aggressive behaviors.	F 282	**F282 (continued)** aide data sheet. Inservicing will be initiated on 9/7/10 and continued at multiple small group sessions through 9/10/10 . The Director of Nursing will be responsible to arrange or provide training for any CNAs who have not completed the training prior to the last session on 9/10/10 before their next shift worked. The Care Plan team including Director of Nursing, MDS Coordinator, Unit Manager, Social Service Director, Activity Director, Dietary Director, Rehab Director and Administrator, were provided training regarding updating the plan of care as conditions arise and monitoring the effectiveness of the approaches that are in place. The training was conducted by Quality Management Specialist Nurses on 8/31/10. The process was revised to include physicians orders being brought to the morning Abbreviated Quality Assurance Meeting. The orders will be reviewed along with condition changes noted on the 24 hour reports. Any change in condition or order that requires a care plan update will be assigned to a team member, usually the Unit Manager, to add the intervention that is decided upon. The person who updates the care plan will report back to the Director of Nursing that the plan was updated in the next day's Abbreviated Quality Assurance Meeting. If conditions or behaviors are identified that suggest that the current care plan is ineffective, the care plan will be brought to the AQA meeting for revision. On weekends the care plans will continue to be updated with needed revisions by the charge nurses.	